**WRMA**
Walter R. McDonald & Associates, Inc.

*FINDINGS FROM THE*

# SERVICE AREA 8 FOCUS GROUPS

CONDUCTED FOR THE MENTAL HEALTH SERVICES ACT
PREVENTION AND EARLY INTERVENTION PLAN
IN LOS ANGELES COUNTY

**October 2008**

***Prepared for:***
**The Los Angeles County Department of Mental Health**

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## ACKNOWLEDGEMENTS

Special thanks and acknowledgement go to the Los Angeles County Department of Mental Health (LACDMH) PEI staff, the Focus Group Coordinators, and to each of those participating in the Community Focus Groups. We greatly appreciate the assistance we received from the LACDMH PEI staff and the Focus Group Coordinators in coordinating and scheduling the focus groups. We also extend special thanks to all the focus group participants for taking the time to meet with us and for sharing with us their perspectives. The wealth of information provided during each of the focus group discussions was invaluable to the formation of this report.

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## I. Introduction

The Los Angeles County Department of Mental Health (LACDMH) is engaged in an intensive, inclusive, and multi-faceted approach to developing the County's Prevention and Early Intervention (PEI) Plan to be funded through the Mental Health Services Act (MHSA) enacted by California voters in 2004.

The focus for developing the PEI Plan is at the Service Area level, utilizing informational meetings, key stakeholder interviews, focus groups, and community forums in each of the eight geographic areas of Los Angeles County. Because each Service Area has distinct and varying populations, geography, and resources, it is critical for PEI services to be specific and responsive to regional and community-based needs.

The California Department of Mental Health (CDMH) has defined *mental health prevention* as reducing risk factors or stressors, building protective factors and skills, and increasing support to allow individuals to function well in challenging circumstances. Whereas, *mental health early intervention* involves a short duration (usually less than one year) and relatively low-intensity intervention to measurably improve a mental health problem or concern early in its manifestation and avoid the need for more extensive mental health treatment or services later.

In addition, CDMH has targeted five community mental health needs, six priority populations, and six statewide efforts for the PEI Program, and has identified seven sectors that counties must partner with to develop their PEI Plan.

This report presents the findings from the Community Focus Groups conducted in Service Area 8. Each service area will receive a report of the findings specific to the focus groups selected to speak on its behalf. In addition, a comprehensive final report will be produced presenting aggregate findings across focus groups as well as findings from the individual service area reports.

## II. Methodology

Participants

Each focus group was comprised of no more than 10 participants. Participants were drawn from existing groups/organizations for the purpose of participating in a discussion about the mental health service needs, barriers, and strategies in their respective communities.

- As with the Key Individual Interviews, the focus groups were selected based on Service Area representation and the categories of MHSA age group, sector, priority population, and key community mental health needs for PEI. Utilizing recommendations made from LACDMH District Chiefs, Service Area Advisory Committee (SAAC) members, and other stakeholders throughout the county familiar with the categories, LACDMH selected focus groups that qualified in at least two PEI categories.

- LACDMH identified a focus group coordinator from each community group/organization selected. The focus group coordinator sought participation in the focus group from among the organization's membership. Focus group coordinators were asked to identify and invite a diverse group of participants who could speak about service needs, barriers, and recommended strategies for their Service Area.

- A total of 56 individuals from the following six organizations in Service Area 8 were asked to participate in their respective organization's focus group:

1. City of Long Beach Health Department's Senior Links Program;
2. Harbor Regional Center;
3. Interagency Pacific Islanders comprised of the Tongan Community Service Center, Tongan American Youth Foundation, Samoan National Nurses Association, and Guam Communications Network;
4. The Center Long Beach – LGBT TAY Mentoring Youth Through Empowerment Program and Twenty Something Group;
5. Richstone Family Center; and,
6. WomenShelter of Long Beach.

- The agencies from which the focus groups were drawn have been in existence between one and 35 years and support between 8 and 9,500 members, with members ranging in age from 16 to over 60.

- The ethnic composition of the six participating agencies is very diverse. Caucasian and Asian Pacific Islanders are represented in four of the six participating agencies. African Americans and Latino/Hispanic communities are represented in three of the six agencies; Eastern European/Middle Eastern and Caucasian communities are represented in two of the six; and, other groups represented among the six agencies included Turkish, Vietnamese, Tongan, Chamorro, and individuals from mixed ethnic and cultural backgrounds.

- Finally, the six participating agencies represent the following community sectors in Service Area 8: Community Family Resource Centers, Education, Employment, Health, Individuals with Serious Mental Illness, Mental Health Service Providers, Social Services, and Underserved Communities.

Procedures

Each focus group coordinator worked closely with a member of the contracted consulting team to arrange focus group dates, times, and locations.

The focus groups were conducted at the organization/agency from which focus group participants were drawn or other community-based locations. The focus groups were audio recorded and took about two hours to complete. Nine key questions, some of which contained sub-questions, were posed to group participants. The questions were designed to produce information needed to inform the PEI planning process. The Focus Group Guide can be found in **Appendix A**.

Facilitators representing LACDMH at the focus groups as a neutral third party included a team of three staff members from Walter R. McDonald & Associates, Inc. (WRMA) and their subcontractors, EvalCorp Research & Consulting, Inc., and Laura Valles and Associates, LLC. One team member facilitated the focus group, another observed and documented, and a third recorded participants' responses on flip charts, which participants could refer to throughout the focus group.

Focus group documentation included: The Focus Group Profile, the Focus Group Participant Profile, a signed Consent Form indicating that the focus group would be audio recorded, the observer's electronic notes, the paraphrased responses from participants, an audio recording of the focus group, and a transcript of the focus group developed from the audio recording. A report was written by the focus group team observer, summarizing the group's responses to the questions. Information from each focus group was coded so that the data could be analyzed and presented in summary format.

## III. Knowledge of the PEI Planning Process

Participant Participation in the PEI Planning Process (Q1)

The first questions focus group participants were asked to answer was "Have you or your group taken part in the Los Angeles County Department of Mental Health's PEI planning process? And, if so, how?" Of the 56 focus group participants, seven had participated in the PEI planning process in three key ways. One participant attended a PEI Steering Committee Meeting; others either participated in Service Area Advisory Committee (SAAC) 8 meetings or in informational meetings about PEI offered at various community agencies.

## IV. Service Area and Priority Population Representation

Service Area (Q2)

When focus group participants were asked which service area they represented, 48 of 56 participants indicated Service Area 8; and, two participants represent Service Area 6; one Service Area 7, and two Countywide. However, some of the 48 participants representing Service Area 8 also represent additional service areas. Ten of the 48 represent Service Area 6, three represent Service Area 5, and six represent Service Area 7.

Priority Populations (Q2a)

The CDMH has identified the following six priority populations for PEI services: 1) Underserved cultural populations; 2) Individuals experiencing the onset of serious psychiatric illness; 3) Children and youth in stressed families; 4) Trauma-exposed individuals; 5) Children at risk for school failure; and, 6) Children and youth at risk of or experiencing juvenile justice involvement. Focus group participants were asked to select the priority populations they represent. As shown in **Table 1**, of the six priority populations, over 80 percent of participants represent Underserved cultural populations and Trauma-exposed individuals. Between 46 and 73 percent of participants represent the remaining four priority populations.

**Table 1: PEI Priority Populations**

| PEI Priority Populations | Number of Participants | Percent of Participants (n=56) |
|---|---|---|
| Underserved cultural populations | 49 | 88% |
| Trauma-exposed individuals | 48 | 86% |
| Individuals experiencing the onset of serious psychiatric illness | 41 | 73% |
| Children/youth in stressed families | 33 | 59% |
| Children at risk of school failure | 28 | 50% |
| Children/youth at risk of or experiencing juvenile justice involvement | 26 | 46% |

## V. Community Mental Health Needs and Impacts

Mental Health Needs in the Community (Q3 and Q3a)

Each focus group participant identified the mental health needs in their community based on five MHSA categories: 1) Disparities in access to mental health services; 2) Psycho-social impact of trauma; 3) At-risk children, youth, and young adult populations; 4) Stigma and discrimination; and, 5) Suicide risk. Of these five needs, 91 percent of the focus group participants indicated that Disparities in access to mental health is a predominant mental health need in the communities they serve (see **Table 2**). It should be noted that three of the focus groups considered all of the mental health needs important to the PEI plan.

**Table 2: PEI Mental Health Needs**

| PEI Mental Health Need | Number of Participants | Percent of Participants (n=55*) |
|---|---|---|
| Disparities in access to mental health services | 45 | 91% |
| Psycho-social impact of trauma | 41 | 84% |
| Suicide Risk | 35 | 73% |
| Stigma and discrimination | 32 | 67% |
| At-risk children, youth, and young adult populations | 39 | 65% |

*One participant did not select any of the mental health needs.

When asked to identify the top three mental health needs from among the list of five determined by CDMH, five of the six focus groups who prioritized mental health needs identified Stigma and discrimination as one of the top needs (see **Table 3**). A Cambodian participant noted the struggles of living with stigma and discrimination in the United States, *"Because before we used to live in a very difficult time during the Pol Pot. When we come to this country, we should have lived happily -- but it is not like what we expected. There are many difficulties."*

Receiving equal weight, Disparities in access to mental health services and Suicide risk were the second highest needs selected by four of the five focus groups. Similarly, three of the six focus groups in Service Area 8 considered both At-risk children, youth, and young adult populations and Psycho-social impact of trauma a third priority.

**Table 3: Priority PEI Mental Health Needs**

| Priority PEI Mental Health Needs | Number of Groups (n=6)* | Priority |
|---|---|---|
| Stigma and discrimination | 5 | 1 |
| Disparities in access to mental health services | 4 | 2 |
| Suicide Risk | 4 | 2 |
| At-risk children, youth, and young adult populations | 3 | 3 |
| Psycho-social impact of trauma | 3 | 3 |

Impact of the Mental Health Needs on the Community (Q4)
As presented in **Table 4**, focus group participants reflected upon and relayed the negative impact unmet mental health needs have had on their communities. The two most highly mentioned impacts were a range of concerns about service access as well as the mental health issues afflicting community members.

With respect to access, participants were concerned about the stigma associated with mental health services in the general population, but also among seniors, and among different ethnic populations such as the African American, Hispanic, and Chomorro communities. One focus group participant illustrated the seriousness of this concern with the following comment, *"I would say that same thing about the African-American community [as was said about the Hispanic community]. It's like if you do have, I guess, a mental disorder or anything like that it's definitely you keep it to yourself, don't speak about it. And when we do go to get resources not necessarily in the neighborhoods that we live in, we do have to go, like halfway across town to get those services."*

Among seniors and the developmentally disabled community, the stigma associated with mental health labels causes resistance in receiving services. For example, some families with developmentally disabled children hide behind the developmental disability, preferring that their child be labeled with a disability rather than a mental illness. Said one focus group participant, *"There is this very strange phenomenon of people who would rather be identified as Regional Center clients and not mental health patients so they can have clearly diagnosable conditions. But they don't want to seek mental health services because then they are discriminated against and stigmatized by both ends. And so you have those who want to be Regional Center and not mental health, and those that would prefer to be mental health and not developmentally disabled, and yet they look the same. I mean, characteristically and behaviorally, they look the same."*

Participants also noted a lack of culturally and linguistically competent interpreters and staff to serve the needs of monolingual populations, resulting in consumers who *"… walk out and never go back,"* exacerbated symptoms, and eventual crisis states. Also mentioned was the lack of transportation, particularly for TAY youth who might not be able to afford it on their own, which coincides with the inability to access services due to costs, lack of insurance, and strict eligibility criteria. Among seniors, limited income, lack of financial support, no social security, and no insurance contributes greatly to the lack of service access and provision.

For seniors, general access to services is an issue. Seniors have difficulty accessing appropriate services that either correctly identify and/or intervene early before symptoms become exacerbated and require emergency care. Once the emergency care stage is reached, the lack of available and appropriate services prevents them from getting the care they need, sometimes resulting in death.

With respect to mental health issues, depression and suicide risk are at the forefront. WomenShelter of Long Beach and Interagency Pacific Islanders focus groups pointed out the prevalence of depression and suicide in their communities. One focus group participant noted, *"I see many Cambodians with problems. Sometimes I see some people are depressed but I don't know who I can share with? So, I just try to keep it inside myself. Sometimes it leads to other illnesses."* In addition, isolation among seniors leads to depression, as well as substance abuse. *"So, isolation goes across different living arrangements. It doesn't matter. And even seniors in Leisure World are very isolated and there is a significant substance abuse problem among females as well."*

Mental health conditions also are a concern in the developmentally disabled community. Participants pointed out that there is a higher probability of serious mental illness among the developmentally disabled, with community members exhibiting gender disorders, schizophrenia, and a full range of Axis 1 diagnoses.

Aside from access and mental health issues, focus group participants discussed the behavioral, social, and emotional outcomes that are occurring in their communities, particularly among youth. These include such negative outcomes as acting out in school, failing school and/or dropping out, becoming involved in gangs, engaging in criminal activity, and interfacing with the law. One participant noted the struggles parents have with these issues, stating that, *"It's a huge stress for a Latino mom who wants to help her child succeed but cannot. Because maybe she doesn't speak adequate English and her kid gets into second grade and his reading level in English is already exceeding hers. And so, she's there, she wants to help but she can't. Those issues are significant to mental health … because what we see then is kids who haven't done well in school, who are more and more feeling outcasted, and are more and more looking for a place to fit in, which oftentimes ends up being in the gangs and violence and alcohol and dropout and all of those other things. So, there is a really significant link between the academic and the mental health."*

Community and family violence and abuse are also outcomes of the mounting mental health needs prioritized in **Table 3** on the previous page. Focus group participants talked about increased child abuse and domestic violence, shootings in their communities, and how the developmentally disabled are easy targets for abuse due to their disability. One participant reported, *"I see a lot of self-medicating when you start talking about the abuse issues because they're trying to alleviate the symptoms of the mental health issue. Then you start getting into the alcoholism and drug addiction, even if they are prescribed psychotropic medications. You know, a drink is a lot more effective. So then, it does turn into the triple diagnosis."*

Other community concerns included:

- The lack of funding and resources to escape domestic violence, obtain legal services, provide extra-curricular activities for children, offer mental health services to the developmentally disabled, and address other community issues.
- Due to lack of funding and resources, the level of poverty, crime, unemployment, and violence are on the rise, which in turn, contributes to the breakdown of community and family systems accompanied by a growing sense of hopelessness.

**Table 4: Ways in which Mental Health Needs Impact the Community**

| Community Impact | Number of Mentions |
|---|---|
| Access Issues | **19** |
| • Stigma | 6 |
| • Service Linguistic/Cultural Competency | 4 |
| • Cost/Insurance/Medi-Cal/Eligibility Criteria | 3 |
| • Transportation | 2 |
| • Available Services/Capacity | 2 |
| • General Service Access | 2 |
| Mental Health Issues | **11** |
| • Depression/Suicide Risk | 6 |
| • General Mental Health Issues | 3 |
| • Co-occurring Disorders | 1 |
| • Substance Abuse | 1 |
| Community/Family Violence/Abuse | **5** |
| Unaddressed/Exacerbated Mental Health Conditions/Higher levels of Care/ Poor Outcomes | **5** |
| Funding and Resources | **5** |
| Social/Economic Conditions | **5** |
| Behavioral/Social/Emotional Issues/Outcomes | **4** |
| Outreach/Education/Awareness | **3** |
| • General | 1 |
| • Families/Parents | 1 |
| • Linguistic/Culturally Appropriate Messaging | 1 |
| Community/Family Breakdown/Hopelessness | **3** |
| Support System (lack of) | **2** |
| Generational Cycle | **2** |
| Health Care Issues | **2** |
| Medication Issues/Management | **2** |
| Outreach/Education/Awareness-General | **2** |
| Age Categories are Limiting | **1** |
| Child Welfare/Foster Care | **1** |
| Discrimination | **1** |
| Life Transitions Leads to At-risk Conditions | **1** |
| Service Integration/Continuity of Care | **1** |
| Specific Services (lack of) | **1** |
| Other | **8** |

## VI. Existing and Needed Prevention Services/Resources

Existing Prevention Services/Resources (Q5)

The following is a listing of all the existing prevention services identified by the participants across five of the six focus groups. Participants of WomenShelter of Long Beach focus group indicated that there were no existing prevention services. In addition, participants of the Interagency Pacific Islander focus group, while able to identify a few prevention services, emphasized the lack of prevention services accessible to their community, to Tongans or Samoans in particular.

- AB3632, funding for assessment, identification, and referral of children at-risk or with mental health issues in schools

- After-school Programs
    - At churches
    - At schools
- Agencies and Programs on Aging
- Bethlehem Shelter in the Long Beach Area
- Churches, at which
    - Ministers provide support and counseling to individuals and families
    - Youth groups provide activities for children
- Community Support Groups, especially bereavement and caregivers support groups
- Elder Abuse Prevention Team
- Faith-based Organizations, including Jewish Family Community Services
- Families
    - Community members turn to their families with problems; despite the fact that families often are not equipped to cope with the issues due to generational and cultural differences
- Field-based Case Management
    - Field Capable Clinical Services
    - Field Assessment Case Management and Treatment Services
- First 5 LA
    - Parents as Teachers (PAT)
    - Home Instruction for Parents of Preschool Youngsters (HIPPY)
- Full-Service Partnerships
- Gatekeepers
- Geriatric Intervention for Today's Senior
- Harbor Regional Center
    - Community Outreach and Education
- Head Start
- Independence at Home, teaches how to manage money, encourages advocacy, and provides counseling services
- Information Assistance Office, makes referrals for seniors
- LifeWorks
    - Mentoring Program for GLBT 16 to 23 in West Hollywood
- Los Angeles County Multi-Services Senior Programs, offer long-term case management
- Meals-on-Wheels Services, the only connection between the community and the isolated;
- Mental Health Association (MHA) Village Integrated Service Agency
    - Mental health services for different age groups
    - TAY Academy
- Multi-services Senior Center in the Village
- New Hope Grief Support
- Outpatient-based Services
    - Memorial Counseling Associates and Pacific Hospital
    - Senior Links Program, for medical or psychiatric problems
- Passages
- PET Team, assistance limited to those who are in crisis and/or admit to being suicidal
- Richstone Family Center
    - Prevention Services
    - Anger Management
    - Domestic Violence
    - Parent-Child Interactive Therapy (PCIT), for families with children ages 2 to 7

    - Parenting Classes, groups offered in schools or on an in-home basis
    - School-based Counseling Services, at elementary and middles schools in the Lennox School District
- Senior Centers
- Senior Police Partners, make referrals to services such as
    - Field Assessment Case Management and Treatment Services
    - Senior Links
- Social Skills Programs, for withdrawn students at local schools in Service Area 8
- The Center, provides a safe haven for youth
    - Lesbian Chat Support Groups
    - 20 Something Support Group
    - Mentoring Youth through Training Empowerment (MYTE) Program, offers healthy relationship workshops and leadership training
- Urgent Care Psychiatric Services on Paramount
- Women's Domestic Violence Shelter, downtown Long Beach

<u>Needed Prevention Services/Resources</u> (Q5a)
All six focus groups identified a number of needed prevention services and/or resources as reflected by the list below. The needed prevention services are organized by type of service/resource and listed from highest to lowest number of needed services/resources cited under each service/resource type.

*Specific Services and Resources including Counseling and Support Groups*

- Financially accessible therapy.
- Small group therapy and counseling to help clients deal with emotions and stressors.
- Counseling services for domestic violence.
- Mentoring programs and peer support groups for all ages.
- After school mentoring programs for youth.
- Support services to help developmentally disabled individuals deal with the death of their parents and other life transitions.
- High school counselors and mentors who are Pacific Islanders and understand the needs of the community.
- Women’s groups.
- Better quality after-school programs that include workshops on respect, tolerance, individuality, and issues youth face in school, in their homes, and in their communities.
- More crisis management as a preventive measure.
- More anger management education and parent support groups, particularly for fathers.
- More psychiatrists knowledgeable about developmental and mental health disorders.
- Programs like Promotoras that provide community education about developmental disabilities.
- School programs that teach students how to be aware of and prevent problems.
- School programs that serve the Pacific Islander community.
- Legal aid for undocumented people.
- After-school programs
- Affordable housing
- Homeless support services, such as shelters and food banks to support seniors.
- Delivery of groceries to seniors.
- Support for first-responders such as paramedics and police.
- Urgent care to catch early signs of mental illness among seniors
- In-house psychiatrists through Gateway.

*"We don't have enough counselors in high schools where the majority of Pacific Islander students are enrolled. In Carson High School, there are maybe one or two, three teachers there. The rest of our high schools, not one high school, San Pedro High School, Gardena High, there are no counselors that would help these kids, that would understand the Pacific Islander kids, the problems at home. That's why there are a high percentage of kids who drop out and get involved with all these gang activities after school. There are a lot of things going on at home. Your parents are not home, maybe the grandparents are taking care of the kids or an older child is taking care of the rest of the kids, the parents are working and -- it's a lot of things involved."*

*Outreach, Education, and Awareness Services and Resources*

- Outreach to let people know about existing programs and the types of services they offer.
- Outreach into the community in order to decrease the stigma associated with mental health and increase access to services.
- Reach families using existing centers and resources, such as churches.
- Develop in-language resources; make them accessible to faith-based and community organizations, such as social club leaders for Chamorro and churches for Samoan and Tongan communities.
- Distribute translated educational materials.
- Outreach to homes to reach the community and bring them into services in order to overcome stigma and trust issues. Outreach needs to be done by a trusted community member to be effective.
- Education for seniors about stigma and available services.
- Education for youth, parents, extended family, and church leaders.
- Proactive education and/or training for faith-based organizations, law enforcement, paramedics, physicians, pastors, paraprofessionals, nursing students, emergency medical teams, Adult Protective Services, and service providers.
- Parenting classes.
- Education about mental health illnesses such as depression and anxiety (especially for Hispanic, new mothers), domestic violence and abuse (particularly for students), and mental health services available.
- Different modalities for providing education to different audiences/generations, such as skits for youth.
- Training church and community leaders to become better equipped to deal with mental health issues.
- Training of community advocates and mental health workers on confidentiality, as trust and confidentiality are major issues.

*"There is no knowledge of mental health in the Samoan community. In Samoa, when somebody has a mental illness, they kind of look down to these people, they think it's a behavior -- it's not an illness. It's not a mental health problem. It's 'crazy' and they kind of make fun of that person instead of trying to help. So there is a lack of knowledge or lack of understanding of what mental health is in the Samoan community. We need to identify problems early on before it gets worse and make some referrals to get some help. So, education is very important here in our community."*

*Services and Resources that Increase Access*

- More mental health services in general.
- Culturally sensitive and linguistically appropriate services.
- More mental health services with quicker access to referrals.
- Geographically accessible therapy.

- Access to Medicare and affordable medical insurance.
- Free or affordable services for older adults lacking medical insurance or the ability to pay.
- Free bus passes.
- Accessible transportation for seniors.
- Support services such as child care and bus tokens or taxi vouchers to help consumers access services.

*Funding and Resources*

- General financial assistance for families.
- Funding to expand existing services.
- Additional funding and expansion of effective mental health programs or other peer support programs, especially for seniors.

*Services that Provide Coordinated and Transitional Care*

- Better coordination of mental health and developmentally disabled services.
- Transitional/after care services assisting developmentally disabled as they move from hospitals to group homes.
- Coordinated services so that community members are not scrambling to pull together resources in order to meet the service needs in the community.

*Provider and Staff Education, Training, and Recruitment*

- Cross training should be mandatory for developmental disability and mental health professionals as clients can have similar issues. Prevention, early intervention, and treatment methods can be adapted to work with the developmentally disabled population.
- More counselors and training of current counselors to better serve the community; provide scholarships or funding for Pacific Islanders to become counselors and social workers.

*"I would like to see a cross training. Having been trained as a psychologist, we're not taught that the developmentally disabled are the same. It's like a mental health issue is just an issue that can affect anybody, whether you're typical or you're developmentally disabled, or you're mute, or you're deaf, you still can have those same issues. And I think that there's this sense -- and it goes to that stigma that professionals feel as though they're incompetent."*

*Services and Resources that Raise Staff Quality*

- Therapy provided by quality professionals: who take a personalized/consumer-oriented approach, establish rapport, and conduct therapy based on mutual interests; who can relate to the GLBT experience; who are trained to address GLBT issues; and who understand and respect client confidentiality

*Location-based Services*

- School-based services that included parents and families.
- Non-discriminatory, accessible mental health services such as home supports and drop-in centers in the community as many clients have limited resources and ability to travel.
- Field-based services in general, as well as field-based services that can do house calls.

*Medication Management Services*

- Medication management, education, and follow-up care.
- Education for parents regarding medication; long-term over medication may lead to mental health disorders; as such, diagnosing professionals need to provide more information to clients and their families.

*Other Services and Resources*

- Anger management education and parent support groups.
- Regular screenings to detect learning disabilities and mental health issues early.
- A DMH presence at Harbor Regional Center to educate families, provide support groups, and help them deal with diagnoses and transitions.
- Case management and services for older adults.
- Services that will help older adults navigate the system.

Priority Prevention Services/Resources (Q5b)
When each focus group was asked to prioritize the needed prevention services they had listed in response to the prior question, five of the six selected three priority services, as presented in **Table 5** These priorities reflect prevention services that would

- reduce stigma and discrimination;
- promote outreach and education among all PEI constituencies;
- train and cross-train providers and their staff;
- are tailored to the needs of consumers;
- implement field-based services;
- provide insurance in order to access services;
- secure funding to provide needed services; and,
- offer mentoring, support groups, screenings, and early diagnosis.

Additional priorities listed by two of the focus groups were: 1) more crisis prevention and management services (which could result from cross-training); and 2) therapy that is geographically and financially accessible, and provided by quality professionals who take a personalized and client-centered, consumer-oriented approach to therapy.

**Table 5: Priority Prevention Services/Resources (n=6)**

| Focus Group | Priority 1 | Priority 2 | Priority 3 |
|---|---|---|---|
| **The Center LGBT TAY Groups** | After-school programs that teach tolerance. | Mental health organizations geared toward the needs of the LGBT. | Screenings and diagnosis for dyslexia, learning disabilities and other issues. |
| **Harbor Regional Center** | Cross-training for developmental disability and mental health professionals. | Non-discriminatory, equal access to services for the developmentally disabled. | Housing a mental health professional on-site at the Harbor Regional Center. |
| **Interagency Pacific Islanders** | Education for youth, parents, extended families, and church leaders to overcome stigma and bring community members into services. | Training of mental health advocates, counselors, and social workers to provide high quality, linguistically appropriate services. | Funding to provide culturally competent services that the community trusts. |
| **Long Beach Senior Links Program** | Field-based services. | Education and training for seniors as well as for professionals who work with seniors. | Funding and resources. |
| **Richstone Family Center** | Education about mental health illnesses and abuse/domestic violence. | Provision of support services such as childcare and transportation. | Mentoring and peer support programs (for fathers in particular). |
| **WomenShelter of Long Beach** | Medicare and medical insurance. | Financial assistance. | Transportation. |

Note: Priorities not listed in rank order

Locations for Prevention Services/Resources (Q5c)

**Table 6** presents the locations at which focus groups would like to see prevention services offered. All four focus groups responding to this question suggested locating prevention services at community centers or organizations and schools; and, two of the four promoted offering home-based services. Other locations offered by one of the four participating focus groups can be found in the table below.

**Table 6: Prevention Service Locations**

| Prevention Service Locations | Number of Groups (n=4)* |
|---|---|
| Community Centers/Organizations | 4 |
| Schools | 4 |
| Homes | 2 |
| Co-locating Services (i.e., mental health and developmental disabilities) | 1 |
| Community Colleges | 1 |
| Faith-based Organizations | 1 |
| House Parties | 1 |
| Places easily accessible to the public | 1 |

*Two focus groups did not provide preferred locations for prevention services

## VII. Existing and Needed Early Intervention Services

Existing Early Intervention Services/Resources (Q6)

The following is a listing of all the existing early intervention services identified by the participants across the six focus groups. Among the six focus groups, two noted the dearth of early intervention services and others had difficulty identifying services. A couple of the groups also pointed out the high degree of overlap between the prevention and early intervention services they cited.

- Adult Day Health Care
- Adult Respite Care
- After-school youth programs in general
- After school programs that provide peer support, tutoring, and activities
- Community services in general, but not accessible to the Pacific Islander community
- Day Care Center
- Early childhood intervention services are available for Axis I disorders at agencies such as the Children's Institute, For the Child, Child Guidance Center, and ALAMA
- Early Head Start
- Faith-based Programs
- Field Assessment Case Treatment
- Field Capable Clinical Services
- First 5 LA
    - Home Instruction for Parents with Preschool Youth (HIPPY)
    - Parents as Teachers (PAT)
    - School readiness programs that provide screenings, parenting education, in-home services, and mental health referrals
- Full Service Partnerships (FSP), provides residential placement for homeless and at-risk populations
- Health Care Center
- Individual, group, and family counseling services at local agencies
- Inpatient and outpatient psychiatric services
- Life Works
- Medicare
- MHA Village Integrated Services
    - Supports individuals at-risk of suicide
    - TAY Academy
- Older Adult Services
- Pacific Hospital, supports individuals at-risk of suicide
    - Psychiatric Evaluation Unit
- Polynesian dance crew, Tupulanga, a cultural youth group that provides after-school programming to the Samoan community
- Primary Care Physicians
- Programs for individuals with disabilities
- Regional Centers, provide some services to mentally challenged and developmentally delayed individuals, such as Cole Vocational
- Richstone Family Center
    - School-based counseling services
    - Parent-Child Interactive Therapy (PCIT), for families with children ages 2 to 7
- RSVP
- Schools
    - Individual Education Plans (IEP)

    - Other school-based services; however, these services are often limited and not accessible to Pacific Islanders due to language and cultural barriers
    - School liaisons for mental health needs that impact student learning, such as ADHD
- Senior Centers
- Senior Police Partners
- Shelters
- The Center, provides a safe haven for youth
    - Mentoring Youth through Training Empowerment (MYTE) Program, offers healthy relationship workshops and leadership training
    - Identifies youth at-risk of alcohol and drug abuse
- The Katturan Chamoru Performers (KCP)
    - Teach youth the culture at a very young age
    - Educate members about consequences
    - Provide a lot of positive reinforcement and assistance to members
- The Samoan National Nurses Association, only center in the Samoan community
    - Trusted nurses provide outreach, presentations, and limited identification of mental health issues
- Transportations services
- Women's groups and services
- Zero to Three, provides family-oriented parent-child counseling

<u>Needed Early Intervention Services/Resources</u> (Q6a)
All six focus groups identified a number of needed early intervention services and/or resources as reflected by the list below. The needed early intervention services are organized by type of service/resource and listed from the highest to the lowest number of needed services/resources cited under each service/resource type. (Services with an asterisk mark specific services referenced in the next section on priorities).

*Specific Services and Resources including Counseling and Support Groups*

- Suicide prevention services and training.
- 24-hour care centers (not a telephone hot-line) that will pick up consumers and take them to a mental health center for services. As one participant noted, *" … being able to sit down and talk to someone face to face is a little bit more personal."*
- More vocational and career development programs such as Junior Achievement and internships.
- Shelters.
- Geriatric assessment.*
- Wellness activities centers able to address the needs of seniors.*
- An activity facilitator to welcome the seniors and show them around.*
- Partnerships with peer advocates to build relationships (e.g. Jewish Family and Children Services).*
- Friendly phone calls to seniors and expanded visitation. Jewish Family and Children Services offer a friendly visitor program in which a telephone call leads to a visit.*
- Service providers to establish a relationship and build trust with the seniors they serve.*
- Women's groups.
- Youth programs.
- Socialization groups for seniors.*
- Support groups at Senior Centers.*
- More support groups and resources at schools, especially high schools.

- Counseling, education and support services for parents of developmentally disabled children to help them deal with trauma.
- Mental health counseling in jails and emergency rooms.
- Counseling for kids and adults.

*"The typical participant in an anger management class is a male, usually a father, who's been involved in some typically more minor type domestic violence or issues with child abuse because this is not an abuser's class. This is the generic 10-week anger management class. And so much for the benefit they get out of that class, sometimes is the interaction with other participants. Case of point, sometimes after the class is over, they're in the parking lot for nearly half an hour sharing their stories and getting a lot of support from each other. So, I thought about father-support groups that would enable them to be able to come together and be able to draw support from each other and not feel like they're the only guy out there that's going through this situation, which would enable them to be able to continue to meet the needs that they should be doing, whether it was relational or parenting."*

*Services and Resources that Increase Access*

- More early intervention services that address serious mental illnesses in youth.
- Improved access to mental health services by students (e.g., satellite sites and peer counseling and referral programs).
- Equal access to mental health services for developmentally disabled clients/students in schools and community.
- Culturally sensitive services that offer peer support, and are accessible, affordable, and age sensitive.*
- Greater eligibility for services -- Medi-Cal may not cover psychiatric services, so clients are rejected from mental health system due to their developmental disability status.
- Medicare assistance.
- Transportation assistance.
- Overcome the stigma that developmentally disabled cannot benefit from talk therapy or related services (many psychiatrists are unwilling to treat developmentally disabled with mental health needs).

*"What happens is because mental retardation is not treatable -- at least it's not funded as being treatable, so a lot of our folks are rejected from a mental health system even though they may have an additional disorder… which ever it maybe. And that is treatable. Anyone could treat that, but they don't. Even at DMH there's a misunderstanding of saying, 'We're not allowed to fund for that,' and it's actually not true. They can fund for it, but it's a misunderstanding based on stigma and lack of understanding. Whatever it may be based, it's preventing access to services."*

*Outreach, Education, and Awareness Services and Resources*

- Parenting education.
- More education to increase awareness of mental health illnesses/issues.
- Education to reduce stigma.*
- Train staff of community and faith-based organizations such as the Guam Communications Network, as well as community leaders, to enable them to identify the early onset of mental health problems.
- Develop ways to publicize existing programs and services.

*Funding and Resources*

- More funding of existing services to increase the number of services available, and provide transportation or child care to increase access to services.
- Funding for community- and faith-based organizations to provide accessible services, training, and education.

*"Funding is very important for us. Our organizations haven't had any programs to target the youth because we haven't had any funding at all for the youth. But we did have some youth programs when we did have some funding. We did tobacco education and an obesity project, but that was it. We would love to see some increased funding from Department of Mental Health, especially here in Los Angeles County where the largest population of Pacific Islanders resides. Besides back home … it's right here in Southern California. And yet, we are still very invisible."*

*Location-based Services*

- Mental health centers on public school campuses (from elementary through college) that serve the developmentally disabled population.
- School-based counseling services, career counseling, and after school activities that are targeted for the Pacific Islander population.

*Service and Resources that Improve the Service Delivery*

- Services that provide more timely intervention; some programs like the Psychiatric Evaluation Unit take a long-time to get to the individual who needs services.
- Translation services.
- Services and staff that support senior strengths and respect their independence.*

*Provider and Staff Education, Training, and Recruitment*

- More staff, particularly psychiatrists and therapists.
- Training for mental health professionals on how to treat developmentally disabled populations, also cross-training for personnel working with developmental disabilities on how to handle mental health issues.
- Education for primary care physicians.*

*Other*

- Increase case management capacity.
- More therapists with similar life-experiences as the LGBT TAY.
- Greater parental involvement in counseling services and education, using a family system approach to school-and community-based services.
- A seamless referral process.*
- System navigators.*

<u>Priority Early Intervention Services/Resources</u> (Q6b)
When each group was asked to prioritize the needed early intervention services they had cited in response to the prior question, five of the six selected three priority services, as shown in **Table 7**. These priorities reflect early intervention services that would

- Increase service access in general, as well as for underserved populations;
- Train providers and their staff;
- Recruit and hire linguistically and culturally competent staff, as well as staff who can relate to consumers;
- Encourage greater support from schools and community-based programs;

- Secure funding to provide needed services; and,
- Offer mentoring or support groups.

An additional priority cited by The Center LGBT TAY Groups was to establish 24-hour Care Centers.

The Long Beach Senior Links Program focus group did not prioritize the needed services identified. They felt strongly that all the needed services listed were equally important and should all be considered as part of the PEI decision-making process. The needed services cited by the Long Beach Senior Links Program focus group participants are identified among the services listed in the previous section by an asterisk.

**Table 7: Priority Early Intervention Services/Resources (n=5)***

| Focus Group | Priority 1 | Priority 2 | Priority 3 |
|---|---|---|---|
| **The Center LGBT TAY Groups** | More support groups and resources at schools, especially high schools. | Greater support for LGBT students from school administrators and teachers. | More therapists with similar life-experiences as the LGBT TAY. |
| **Harbor Regional Center** | Train mental health professionals to work with developmentally disabled. | Equal access for developmentally disabled to services that are not dependent upon Axis 1 diagnosis. | More mental health services overall for the developmentally disabled. |
| **Interagency Pacific Islanders** | Funding for training, education, and the provision of school- and community-based services that are linguistically and culturally competent. | Training and education to provide services that are linguistically and culturally competent. | School- and community-based services that are linguistically and culturally competent. |
| **Richstone Family Center** | More programs offered within community organizations (such as Big Brothers and Sisters, Boy Scouts, etc.) that provide socialization and support education for free. | Increased funding of existing services. | More academic support services. |
| **WomenShelter of Long Beach** | Transportation assistance. | Youth programs. | None provided. |

Note: Priorities not listed in rank order

Locations for Early Intervention Services/Resources (Q6c)

**Table 8** presents the locations at which focus groups would like to see early intervention services offered. All five focus groups that responded to this question suggested locating early intervention services at community centers or organizations. Community-based services were noted as preferred locations by all the responding focus groups, and were closely followed by school-based services, selected by four of the five responding focus groups. Other locations offered can be found in the table below.

**Table 8: Early Intervention Service Locations**

| Early Intervention Service Locations | Number of Groups (n=5)* |
|---|---|
| Community Centers/Organizations | 5 |
| Schools | 4 |
| 24-hour Care Centers | 1 |
| Churches | 1 |
| Emergency Rooms | 1 |
| Jails | 1 |
| Provide services for the developmentally disabled at the same locations where others access services | 1 |
| Via community leaders | 1 |

*One focus group did not provide preferred locations for early intervention services

## VIII. Barriers to Service Access and Strategies to Increase Access

Barriers to Service Access (Q7)

Focus group participants were asked "What keeps people from getting the prevention and/or early intervention services they need?" In response, Service Area 8 focus group participants focused predominantly on various access issues. **Table 9** shows that participants mentioned costs, transportation, and stigma more than any other barriers to service access.

Access issues surrounding costs, insurance, and eligibility issues were mentioned together with the lack of transportation to services, as well as, the lack of culturally and linguistically competent staff and services. Costs, insurance, and Medi-Cal were of particular concern for seniors. Focus group participants noted that insurance is unaffordable to many seniors, and even those who qualify for insurance, still cannot afford the cost of services, often due to strict eligibility criteria.

Comments relating to stigma focused on how the cultural beliefs, shame, and other fears about mental health prevent individuals from seeking help. One focus group participant noted that in the Hispanic community mental health concerns are either not discussed or dismissed. He stated, *"… if we have issues, we just don't bring them up. Like whether we're depressed or we're just sad, you know? They don't bother to look into it."* Another participant talked about how religious stigma prevents people from seeking help because of the negative perception of issues such as mental health and/or sexual orientation in some religious communities, pointing out, *"Cause I know I grew up a Mormon, or LDS, and it was a little secret of the family and it was hard. Having to go to church and be like 'so and so is going to get mental health services,' like, oh, my God, and it was the gossip about that. And I don't know if other people have experienced that with other religions but I know that with religions, from my experience, it was really hard to even want to talk about something like that."*

Focus group participants cited their communities' lack of education and awareness about mental health in general as a barrier to access. Specifically, participants underscored the lack of education and awareness among consumers about what services exist and how to access them. The high need for multi-lingual educational materials on mental health was also mentioned, as well as updated service resource guides.

Three service barriers that received between three and six mentions across focus groups were: 1) uninviting service environments with respect to hours of operation, locations in which services are offered, impersonal intake processes and service delivery, and other accommodations, such as child care; 2) insufficient funding and resources to expand services; and, 3) inability to reach and engage clients who deny the need for services.

Other barriers to service access included:

- Insufficient or unavailable case management services;
- Fear of immigration;
- County locations opposed to one-stop-shops;
- Uncompassionate service providers and staff;
- Nonexistent follow-up or continuum of care; and,
- System of patient diversion, once the most immediate needs of the consumer have been addressed, the consumer is sent off to another service provider, which overloads the county facilities that accept people with no benefits. As a result, the counties divert these patients to other providers who also are overloaded and divert the consumer elsewhere.

It should also be noted that the developmentally disabled community presented some unique barriers to service access that did not fit into the typical categories. Some of the barriers to service access which were specific to the developmentally disabled community concerned the lack of understanding and prejudice between the mental health and developmental disability systems. Focus group participants pointed out that the developmentally disabled with mental illness have little or no understanding of the existing culture and their own vulnerabilities within this culture. As a result, they often seek approval from others, oftentimes exposing themselves to harmful, even illegal, situations which result in additional trauma and exacerbated symptoms. One participant stated, "*The client may have a diagnosis that is separate and apart from the mental retardation such as a personality disorder, but they'll [psychiatrists] refuse to see them because of liability issues.*" Another participant replied, "*I think if people drop their prejudices -- and I think there's a lot of prejudice about developmental disabilities, and a lot of prejudice about people with mental illness. If they can drop those prejudices about each other's systems, we'd work beautifully together.*"

**Table 9: Barriers to Service Access**

| Access Barriers | Number of Mentions |
|---|---|
| Access Issues | **22** |
| • Cost/Insurance/Medi-Cal/Eligibility Criteria | 7 |
| • Transportation | 6 |
| • Stigma | 5 |
| • Service Linguistic/Cultural Competency | 3 |
| • Available Services/Capacity | 1 |
| Outreach/Education/Awareness | **9** |
| • General | 5 |
| • Available Services | 3 |
| • Linguistic/Culturally Appropriate Messaging | 1 |
| Service Operations | **6** |
| Funding and Resources | **4** |
| Service Engagement/Benefits | **3** |
| Sensitive Staff/Can Relate | **2** |
| Case Management | **1** |
| Health Care Issues | **1** |
| Immigration/Cultural Matters | **1** |
| Insufficient Number of Staff | **1** |
| Quality Staff | **1** |
| Service Integration/Continuity of Care | **1** |
| Social/Economic Conditions | **1** |
| Other | **8** |

Strategies to Increase Access (Q8)

As a follow-up to the question about service barriers, focus group participants were asked to discuss the types of strategies that would help people obtain access to the services they needed. One of the key strategies for improving access that emerged from the focus group discussions was broad-based outreach, education, and awareness. As presented in **Table 10**, focus group participants talked about educating community members about mental health, especially different cultural groups, as a viable approach to reducing and/or eliminating stigma. One focus group suggested using a peer advocacy approach to conducting outreach. The participants recommended inviting, for example, transitional-age youth to conduct outreach to their peers about mental health, services available, and how to access them. This approach could then be modeled with different age groups and cultural groups as well.

One participant suggested conducting these forms of social outreach in places where people might not typically access information about mental health such as religious institutions or community organizations. Another participant suggested targeting schools in order to reach ethnic groups such as the Pacific Islanders in the community. This participant also recommended incorporating mental health prevention and early intervention education into the school system; providing elementary and middle school counselors with the tools they need to raise awareness and identify mental health symptoms earlier rather than later; and, training existing community leaders, church personnel, and families on early identification.

Additionally, focus group participants proposed several specific services and strategies designed to increase access. Specific services included:

- Mobile Mental Health Centers that provide services in locations that are easily accessible to consumers, and use creative and non-stigmatizing ways to raise awareness about mental health.
- Have available and/or develop more screening tools to identify mental health symptoms among the developmentally disabled.
- Offer legal aid assistance.

Specific strategies for increasing access to mental health services were predominantly cited by those representing the developmentally disabled. These strategies offer alternative perspectives on how to increase access to services, not only for the developmentally disabled, but also for other underserved populations as well.

- Raise awareness of mental health strategies and therapies effective with the developmentally disabled (or other underserved populations) and integrate them into services.
- Drop preconceptions about developmental disabilities and mental health.
- Secure funding for mental health internships at regional centers so young professionals can become aware of the mental health needs of the developmentally disabled and provide parent education and support groups.
- Secure funding for outreach and education in the larger community focusing on developmental disabilities and mental health, risk factors, ways of coping, and ways of responding.
- Obtain financial assistance through programs such as Supplemental Security Income and/or food stamps.

Focus group participants also noted the need to address access issues directly. For example, provide free or subsidized transportation, such as bus passes; offer more services in general; offer more services in multiple languages; and, lessen eligibility and insurance criteria.

Building partnerships, offering services in different settings, and educating, training, and recruiting mental health staff and providers were equally discussed across focus groups. Developing relationships with schools and across agencies was highlighted; as well as co-locating services in elementary and middle schools, and in a one-stop-shop or old settlement house for seniors. A participant suggested, *"…look at maybe Hawthorne High School or Leuzinger or Lawndale, those three high schools. Polynesians make up maybe 5% of the total population at those high schools. But that's probably three quarters of the Tongan high school students in LA County. So, while it's a really small number of the student body, it's an enormous proportion of the actual community population."* Other participants recommend targeting Carson High School in Carson, Jordan in Long Beach, and Long Beach Poly.

With respect to collaboration and building partnerships, one focus group discussed developing relationships between seniors and service providers, another underscored the need for increased education and communication with the courts, the legal system, DCFS, and families regarding the availability and nature of services that are court mandated. One participant explained, *"We'll get a family who will have been ordered by the court in Monterey Park, DCFS, to receive a number of services before a certain date… and there's no way they're going to get those services before that date. So it's almost like we need to educate our judges as well as to do what's actually out there. Because they're asking these families to do things that are not realistic.* Another participant added, *"Going along with educating and increasing communication between the different courts, the legal*

*system, and DCFS, but it's also including parents in that communication stream so that we're letting them know exactly what these services are and what a realistic timeline is across the board."*

In addition, focus group participants discussed the need to cross-train staff of community-based organizations to identify, be culturally sensitive to, and respond to the mental health needs of community members.

Other strategies on how to improve access to mental health services in Service 8 that were mentioned during the focus group discussions covered the following areas:

- Increase funding of existing resources and for the Pacific Islander community;
- Provide translation services and offer extended service hours;
- Identify symptoms early;
- Provide follow-up or case management;
- Increase access to employment;
- Hire a resource referral person or system navigator to serve as the first point of contact to accessing services.
- Offer user-friendly services: less paper work, contact with real people and not electronic message systems.
- Promote integrated mental health services as an integral part of life.

**Table 10: Strategies to Increase Access**

| Strategies to Increase Access | Number of Mentions |
|---|---|
| Outreach/Education/Awareness | **9** |
| • General | 3 |
| • Specific Locations | 2 |
| • Target Populations | 2 |
| • Specific Mediums | 1 |
| • Linguistic/Culturally Appropriate Messaging | 1 |
| Specific Services | **5** |
| • Various Services | 4 |
| • Counseling/Therapy/Groups/Hotlines | 1 |
| Specific Strategies/Approaches | **5** |
| Access Issues | **7** |
| • Transportation | 4 |
| • Cost/Insurance/Medi-Cal/Eligibility Criteria | 1 |
| • Service Linguistic/Cultural Competency | 1 |
| • Available Services/Capacity | 1 |
| Collaboration/Partnerships/Teams | **4** |
| Location-based Services | **2** |
| Staff/Provider Education/Training/Recruiting | **3** |
| • General | 1 |
| • Linguistic/Culturally Competent | 1 |
| Funding and Resources | **1** |
| Service Operations | **3** |
| Assessment/Identification/Intervention-Early/Better Outcomes | **1** |
| Service Integration/Continuity of Care | **1** |
| Social/Economic Conditions | **1** |
| System Support/Assistance/Navigators | **1** |

## IX. Recommendations for Informing Communities about PEI

Recommendations

When focus group participants were asked to provide recommendations on how to let people know about prevention and early intervention services, focus group participants' responses overwhelmingly underscored the importance of using a multi-faceted outreach, education, and awareness approach (see **Table 11**). Ways of conveying information about prevention and early intervention mental health services included an assortment of typical as well as innovative methods. Typical methods of communicating included public service announcements; multiple medias such as television shows (e.g., Christina), commercials, radio, newspaper, and billboards; and, electronic messaging via Internet websites such as MySpace and Facebook, as well as e-mail. Innovative and creative forms of communication involved involving movie starts and promoting well-being on clothing, at concerts, and at workshops.

Participants also emphasized that outreach and education messages should exercise language diversity and ensure that the languages of the community are represented. In addition, participants indicated that the focus of the outreach and education should be on stigma reduction, avoiding the use of the

term ‘mental health’ in order to help communities overcome their fears and misunderstanding of mental health services. Furthermore, they suggested locations in which to conduct outreach such as at community forums and events that are facilitated by community organizations, such as local churches. These venues have the potential to reach community members that might not otherwise be inclined to participate. Along a similar vein, one focus group suggested using SAAC meetings as a vehicle for providing update and information to the general public about the myriad of services and programs available throughout Los Angeles County. *“SAAC meetings need to be more accessible to each community.”*

In addition to these outreach, education, and awareness approaches, focus group participants mentioned several specific ways in which mental health prevention and early intervention can be discussed. These strategies were wide-ranging and included:

- Establish client advocacy councils that start at the grass roots level and work their way up and out to reach the public. People First is an example of such an effort.
- Encourage developmental disability personnel to become involved in the Service Area Advisory Committees.
- Research best practices on how to communicate about PEI.
- Trust the Service Area 8 Pacific Islander community to address the mental health needs in their own neighborhoods *“ … as there are some things we can get across that others can’t.*”

Finally, one focus group made a strong point of curtailing outreach until services are available and accessible.

**Table 11: Recommendations for Informing Communities about PEI**

| Recommendations | Number of Mentions |
|---|---|
| Outreach/Education/Awareness | **32** |
| • Specific Mediums | 15 |
| • General | 5 |
| • Linguistic/Culturally Appropriate Messaging | 2 |
| • Specific Locations | 5 |
| • Available Services | 1 |
| • Families/Parents | 1 |
| • Messaging | 2 |
| • Target Populations | 1 |
| Specific Strategies/Approaches | **7** |
| Collaboration/Partnerships/Teams | **3** |
| Funding and Resources | **2** |
| Staff /Provider Education/Training/ Recruiting | **2** |
| Community/Client Involvement in MH Process | **1** |
| Other | **2** |

## X. Summary

The focus group participants across Service Area 8 were very diverse representing several sectors, a range of ages, and different underserved cultural populations. They fully engaged in the discussions and told facilitators that they appreciated the opportunity to provide their input about the mental health issues, concerns, barriers, and needs in their communities.

Disparities in access to mental health, and stigma and discrimination were among the top two priority mental health needs in participants' communities. Correspondingly, access issues, in particular stigma, focused on how cultural beliefs, shame, and other fears about mental health often prevent individuals from seeking help. One of the key strategies for reducing stigma and improving access that emerged from the focus group discussions was broad-based outreach, education, and public awareness. The needed prevention and intervention services cited by participants reflected services that would increase service access for underserved ethnic minorities as well as the GLBT, seniors, and the developmental disabilities community; reduce stigma and discrimination; promote outreach and education; and encourage school-based efforts, among others.

# APPENDIX

## APPENDIX A: Focus Group Guide

## FOCUS GROUP QUESTIONS

| Issues | Focus Group Questions |
|---|---|
| *PEI Planning Process* | 1. Have you or your group taken part in the Los Angeles County Department of Mental Health's (DMH) Prevention and Early Intervention (PEI) planning process? If so, how? |
| *Participants' Organizational Affiliation* | These focus groups help us learn more about the types of mental health services and resources that are needed to support the social and emotional well-being in your community and among other groups of people in L.A. County.<br><br>2. Which region or area in L.A. County do you represent or will you be talking about in today's discussion?<br><br>2a. Of the identified priority populations [*facilitator refers/points to visual aid listing priority populations*], which of these groups of people do you represent? |
| *Community Mental Health Needs* | The California State Department of Mental Health said that the Prevention and Early Intervention (PEI) plan should focus on the needs of the following groups: at-risk youth, people who may be at risk of suicide, people who haven't been able to get services, and people who have experienced trauma, stigma and discrimination.<br><br>3. What needs are most important to the group of people you represent?<br><br>*3a. Of the needs that you've listed, which are the top three needs most important to your community?*<br><br>4. What do you see happening in your community because of these needs? (what problems are occurring?) |
| *Prevention and Early Intervention Services* | As we talked about earlier, there is a difference between prevention and early intervention services [*facilitator refers/points to visual aid defining prevention and early intervention*].<br><br>5. What **prevention** services or resources are currently available in your community or among the group of people you represent?<br><br>5a. What **prevention** services or resources are needed?<br>5b. "O*f the prevention services you've listed, which are the top three needed*.<br>5c. *Facilitator probes for information on locations for services.* |

## APPENDIX A: Focus Group Guide

| Issues | Focus Group Questions |
|---|---|
| | 6. What **early intervention** services or resources are currently available in your community or among the group of people you represent?<br><br>6a. What **early intervention** services or resources are needed?<br>6b. *Of the early intervention services you've listed, which are the top three needed in your community?*<br><br>6c. F*acilitator probes for information on locations for services.*<br><br>7. What keeps people from getting the prevention and/or early intervention services they need?<br><br>8. What types of things or strategies would help people get the services they need? |
| *Long Range Planning* | 9. What recommendations do you have for how to let people know about prevention and early intervention services? |